Carolina BioOncology Institute, PLLC

HEALTH HISTORY FORM

(PLEASE COMPLETE ALL FIELDS)

Name:_____ Date of Birth:_____ Current Date:_____

Do you have an Advance Directive Yes / No If no, would you like information Yes / No

Physician/Provider List (PCP, Referring - any provider you would like to receive a copy of your notes)

Physician/Provider Name	Phone number	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY:

Diagnosis or Condition:	Date or Year of Diagnosis:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(continue on back if needed)

Have you ever had a pneumonia vaccine: yes / no If so, when:_____

Please list all **Surgeries/Procedures** you've had and **Date/Year Performed**:

_____

_____

_____

_____

GYNECOLOGICAL HISTORY (for women):

# of pregnancies _____
# of full term births _____
# of preterm births _____
Age at first birth _____
Age at first period _____
Date of last period _____
Average # of days between periods _____

Contraceptive Hormone Use: Yes / No # of years _____
Post-Menopause Use: Yes / No # of years_____
Other Hormone Use: Yes / No # of years_____

Date or year of last pap smear: _____
Results:_____
Date or year of last mammogram:_____
Results:_____

Menopause Status: Pre / Peri / Post / Unknown
Age at menopause _____ Reason: Natural / Removal ovaries / Removal uterus / Total hysterectomy / Surgical / Other

FAMILY HISTORY: Please circle yes or no if a blood relative has ever been diagnosed with any of the following:

		Relationship To You			Relationship To You
diabetes	Yes / No	_____	thyroid disease	Yes / No	_____
heart disease/attack	Yes / No	_____	anemia	Yes / No	_____
high blood pressure	Yes / No	_____	leukemia	Yes / No	_____
stroke	Yes / No	_____	bleeding tendency	Yes / No	_____
osteoporosis	Yes / No	_____	chronic lung disease	Yes / No	_____
kidney disease	Yes / No	_____	melanoma	Yes / No	_____

FAMILY HISTORY FOR COMMON HEREDITARY CANCER SYNDROMES:

Please circle yes or no if a blood relative has ever been diagnosed with any of the following:

Breast & Ovarian Cancer		Relationship to You	Age at Diagnosis
Breast cancer before age 50	Yes / No	_____	_____
Ovarian cancer	Yes / No	_____	_____
Breast & ovarian cancer in an individual or family	Yes / No	_____	_____
Male breast cancer	Yes / No	_____	_____
Breast cancer in both breasts or multiple primary breast cancers	Yes / No	_____	_____
2 or more breast or ovarian cancers in an individual or family	Yes / No	_____	_____
Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	Yes / No	_____	_____
Colon & Uterine Cancer			
10 or more colon polyps found in a lifetime	Yes / No	_____	_____
Uterine cancer before age 50	Yes / No	_____	_____
Colorectal cancer before age 50	Yes / No	_____	_____
Both uterine & colorectal cancer in an individual or family	Yes / No	_____	_____
2 or more uterine or colorectal cancers in an individual or family	Yes / No	_____	_____
Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family	Yes / No	_____	_____

Any other family history of cancer: Yes / No

If yes, list type of cancer & relationship of family member:_____
_____
_____

Please list Health Status as Good, Fair, or Poor

Father
If living: Age_____ Health Status_____
If deceased: Age at death____Cause of death_____

Mother
If living: Age____ Health Status_____
If deceased: Age at death____Cause of death_____

Sister
If living: Age_____ Health Status_____
If deceased: Age at death____Cause of death_____

Sister
If living: Age____ Health Status_____
If deceased: Age at death____ Cause of death_____

Brother
If living: Age_____ Health Status_____
If deceased: Age at death____Cause of death_____

Brother
If living: Age____ Health Status_____
If deceased: Age at death____ Cause of death_____

Son
If living: Age_____ Health Status_____
If deceased: Age at death____Cause of death_____

Son
If living: Age____ Health Status_____
If deceased: Age at death____ Cause of death_____

Daughter
If living: Age_____ Health Status_____
If deceased: Age at death____ Cause of death_____

Daughter
If living: Age____ Health Status_____
If deceased: Age at death____ Cause of death_____

(If additional room needed, continue on back)

SOCIAL HISTORY:

Tobacco use: current / infrequent / past / never
If current, # of years_____ # of packs per day _____
If past, # of years quit_____

Alcohol use: current / infrequent / past / never
If current, # of drinks per week _____ or day _____
If past, # of years quit _____

Type of tobacco used: cigarettes / cigars /chewing tobacco / pipe / snuff

Illicit drug use: current / past / never Type: marijuana / cocaine / other _____

Marital Status: divorced/ legally separated / life partner / married/ married-separated / single / widowed

Birthplace_____ Hobbies_____

Occupation_____

Where do you live: house or apt / nursing home / assisted living facility / incarcerated / homeless

Who lives with you: alone / spouse / significant other / children / parents / friends / others

Circle any exposure to the following: asbestos / benzene / coal / lead / mercury/ radiation / red dye #3 / petroleum products
Xylene / other_____

Current/Previous Military: Yes / No If yes, dates:_____ Locations:_____

Worked in an industrial plant or hospital: Yes / No If yes, dates:_____ Locations:_____

History of blistering sunburns as a child: Yes / No

How often are you active: never / daily activities / occasional exercise / light exercise / regular exercise / extensive exercise

What is your current diet: regular diet / dietary supplements / liquid diet / diabetic diet / vegetarian / tube feeds / TPN

ALLERGIES: List any known drug, food, or environmental allergies:

To what	What type of reaction	Severity of reaction
_____	_____	mild / moderate / severe / life threatening
_____	_____	mild / moderate / severe / life threatening
_____	_____	mild / moderate / severe / life threatening

MEDICATIONS, INCLUDING HERBAL AND OVER THE COUNTER MEDICINES:

Name and Dose	How Often Taken	Start Date	Reason for Taking
Ex: Hydrochlorothiazide 12.5 mg	*Twice a day*	*2013*	*Hypertension*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(If additional room needed, continue on back)

PERSONAL CANCER HISTORY (if applicable):

Type and Location of Cancer:

_____

Date of first diagnosis: _____ Stage (if known): _____

Presenting
symptom(s):_____

Date/type/location of biopsy (if any):_____

Date/Year of first treatment (if any): _____

Type of treatment(s):_____

Date of relapse/progression (if applicable): _____

Subsequent treatment after relapse (if any):_____

Date and type of last treatment:_____

Date and type of last scans (if applicable):_____

Any additional information you would like to share with doctor:
_____
_____
_____
_____

The questions on this form have been answered to the best of my knowledge.

_____ _____
Patient Signature Date

rev 12/2008, 12/2010, 1/13, 12/2014